THE
BOSTON MEDICAL AND SURGICAL JOURNAL.

VOL. LXXIV. THURSDAY, JUNE 21, 1866. NO. 21.

LECTURES ON HERNIA, GIVEN AT THE CITY HOSPITAL, BOSTON.

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[Communicated for the Boston Medical and Surgical Journal.

No. I.—*On the History, Anatomy, Varieties, Statistics and Cause of Hernia.**

THE escape of any viscus from its containing cavity, called hernia, probably owed its name to the Greek ἔρνος, a branch, or offset; an offset from the peritoneum, somewhat analogous in form, and in form alone, to the *diverticula*, which are common as an error of formation in the ileum. This offset, when it becomes sufficiently enlarged to receive the escaping bowel, is called the *hernial sac*.

Various estimates have been made as to the frequency of this infirmity in proportion to all mankind, which vary from one in eight to one in sixteen. Probably a mean of one in twelve is sufficiently correct.

If, then, eight per cent. of all our race are afflicted with hernia, it is not strange that the attention of medical men in all ages should have been directed to its observation, nor that the literature of the subject should be immense in range and exhaustive in research.

Passing by the earlier writers, from Hippocrates and Celsus down, we find not much of any value to us now until about a century ago.

In 1757, Camper published the first plates on Hernia worthy of the name. These were wood-cuts, in folio form, and were sufficiently accurate in anatomy, though rough in execution.

Sir Astley Cooper, in 1804, gave to the world his admirable treatise on Hernia—inguinal, crural and umbilical, as well as the rarer forms.[*] Published in large folio, with steel engravings of good merit, they yet owed their chief excellence to the descriptive text—so terse, clear, simple and direct, that, to our thinking, it has not been equalled since.

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* It is not pretended that these papers on Hernia contain anything essentially original or new. As abstracts of clinical lectures, delivered unwritten, and illustrated by cases, they were subsequently condensed and written off. They are merely short-hand, and it is hoped clear and succinct, notes on rupture. They are designed to render clearer to the student, what we have always found difficult to teach, the anatomy of hernia.

And it is hoped that the subsequent papers on the Differential Diagnosis, the Operations for a Radical Cure, and the Treatment of Irreducible and Strangulated Hernia, may present some points of interest to the physician.

The plates were far surpassed by Scarpa in 1809.[†] The great Italian anatomist was so fortunate as to secure in Anderloni an engraver, who afterwards made himself a familiar name in classic works of art. As illustrations of the anatomy of a region peculiarly difficult to represent, they equal in clearness Albinus and Vesalius in other departments.

From 1806 to 1829, the two Hesselbachs—father and son—who gave their family name to the triangle which lies between the *rectus abdominis* and the obliterated *hypogastric* artery, published monographs on Hernia.

But as exhaustive reviews of the subject, it would be hard to surpass the theses of Cloquet, offered in concours, in Paris, in 1819.[‡] These essays were based on 500 dissections of herniæ in the dead subject, on 200 preparations, and 600 drawings. Such industry may well put to the blush more modern efforts.

Langenbeck, of Berlin, in 1817, published a monograph on Hernia.

Perhaps the best known and most read of later works has been that of Lawrence, in 1838.[§] This is a compendium, in the English language, of all other writings.

Not much later, Morton published, in London, some beautifully colored illustrations of Hernia.

Finally, in 1863, Mr. John Wood issued his monograph on Rupture and its Radical Cure.[‖]

In the fourth volume of Holmes's Surgery will also be found an admirable review of Hernia by Mr. Birkett.

Taken in the order of frequency, oblique inguinal, crural, direct inguinal and umbilical comprise those herniæ which escape through the natural apertures left for the passage of the testis, or round ligament; the femoral vessels, and the omphalo-mesenteric vessels and duct; while thyroid, sciatic, perineal, vaginal and diaphragmatic herniæ are not only far more rare, but differ also in forcing for themselves a passage through the weak spots of the pelvic outlet, or the diaphragm. The term ventral hernia is restricted to that which occurs through a wound of the abdominal walls, or between the *recti* muscles separated by pregnancy; and, finally, internal hernia is a term sometimes applied to strangulation within the abdomen.

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[*] The Anatomy and Surgical Treatment of Inguinal and Congenital Hernia. By Astley Cooper, F.R.S. London. 1804. Folio, with Steel Plates. Also, of Crural and Umbilical Hernia. Folio. 1807.

[†] Sull' Ernie, Memorie Anatomico-Chirurgiche. Di Antonio Scarpa. Edizione Seconda. Pavia. 1819.

[‡] Récherches Anatomiques sur les Hernies de l'Abdomen. Par Jules Cloquet. à Paris. 1817. Récherches sur les Causes et l'Anatomie des Hernies Abdominales; Thèse Soutenue publiquement. Par Jules Cloquet. 1819.

[§] A Treatise on Ruptures. By W. Lawrence, F.R.S. Fifth Edition. London. 1838.

[‖] On Rupture, Inguinal, Crural and Umbilical; the Anatomy, Pathology, Diagnosis, Cause and Prevention; with new methods of effecting a Radical Cure. By John Wood, F.R.C.S. London. 1863.

The terms bubonocele, scrotal hernia, enterocele and epiplocele do not need remark. But there are two terms, used by older writers, which demand explanation, as they might mislead. They are *hernia humoralis,* meaning orchitis; and *hernia varicosa,* a varicocele or cirsocele.

The whole anatomy of oblique inguinal hernia may be summed up in the descent of the testis, and the changes it imposes on the parts through which it passes. The testicle, in the earlier part of the fœtal state, lies just below the kidney, and, like the latter, just behind the peritoneum, by which it is partially enveloped in front. The gubernaculum, or leading string, which guides it to the scrotum, has developed upon it, according to Mr. Curling, three sets of muscular fibres—one set attached to Poupart's ligament, a second to the pubes, and a third to the scrotum. As the testicle descends along the psoas muscle, the first set direct it to the inner abdominal ring; the second draw it through the canal, while the third conduct it to the bottom of the scrotum. The testicle passes through these fibres in its descent, and they become involuted on the spermatic cord, forming the loops extending down from the internal oblique over the cord and returning to the pubes, under the name of cremaster muscle. But the testicle also pushes before it the peritoneum which over-lies it, and thence protruding it in a bag or sac, in its descent through the inguinal canal, carries a double layer before and over it to the bottom of the scrotum. Here the two layers invest the testis in a double covering, with a serous sac between—the cavity of the tunica vaginalis. Just as in all serous investments, the organ lies behind the membrane: one layer invests the testis in front, named the *tunica vaginalis testis,* or *propria;* the other layer adheres to the scrotum, which it lines, under the name of *tunica vaginalis scroti,* or *reflexa.* This may be rather trite anatomy to go over, but it seems necessary to review it, for a fair understanding of the subject. When the testicle descends, it leaves an open pouch of peritoneum behind it, which becomes entirely cut off afterwards, in the normal state. It is upon certain imperfections in this closure that the varieties of oblique hernia and of hydrocele depend.

When the closure of the pouch of peritoneum takes place between the scrotum and the abdomen, the lower pouch is called the *vaginal* process, the upper the *funicular* process of the peritoneum.

The first variation from the normal state is where the pouch does not close at all, and remains one cavity from the abdomen to the bottom of the scrotum. Through this the bowel slips down and forms a congenital hernia, lying in contact with the testis.

In the next form an attempt is made at closure, but is not fully carried out. The common canal becomes occluded at one point near the external ring; the funicular process shrinks up within the inguinal canal, but the vaginal process remains open up to the external ring. Thus we have all connection with the peritoneum closed; but the closed cavity of the tunica vaginalis scroti reaching up on the cord as high as the external abdominal ring. If, then, a hernia protrude, it pushes before it its own pouch of peritoneum, and emerging at the outer ring, descends into or behind the large vaginal sac; and we thus have the anomaly of a rupture covered by two serous sacs instead of one. This is called *encysted* hernia—sometimes infantile hernia, but that is a misnomer.

In the third variety we have the connection between the scrotum and the common peritoneal cavity completely cut off; the vaginal process contracted to a normal size around the testis, but the funicular process dilated and patent for a short distance on the cord. Into this dilatation, which extends from the inner ring to a point an inch, more or less, below the outer one, a knuckle of intestine may gradually descend, and thence creep slowly down into the scrotum, where it does not lie in contact with the testis, but, usually, in front of the tunica vaginalis. This is the form of common oblique hernia, which comes on slowly and spontaneously at some period between childhood and maturity; not congenital, but so gradual that the patient cannot define its exact period of origin. After reaching the scrotum it is not distinguishable from the other ordinary forms of hernia.

Finally, we have the normal and perfect closure, where the vaginal process is converted into a serous sac around the testis, and the funicular process wholly retracted within the inguinal canal, where it assumes the name of infundibulum process, which envelopes the cord at the inner ring. The remains of the original serous passage shrink into an impervious mass, and, together with the traces of the gubernaculum, envelope the cord in loose areolar tissue. This, then, is the case in which either oblique or direct hernia occurs from a strain, or rupture, forms its own proper sac of peritoneum, emerges, in either case, at the outer ring, and descends into the scrotum in front of the testis and tunica vaginalis; and the only difference in the covering of the hernia is, that when oblique it is surrounded by the fibres of the cremaster, and when direct it pushes before it the conjoined tendon.

The same varieties of closure of the pouch of peritoneum cause and explain the varieties of hydrocele.

If the cavity is entirely unclosed, we may have a congenital hydrocele, where the fluid will return into the abdomen.

The vaginal process may be closed below, and one or more separate serous pouches exist above on the cord, either without or within the inguinal canal, and this constitutes hydrocele of the cord; or, finally, we may have entire closure above and below, and dropsy of the cavity of the tunica vaginalis testis and reflexa, constituting common hydrocele, beginning at the bottom of the scrotum.

Somewhat analogous changes occur in the passage of the round ligament in the female; and the funicular process of peritoneum which remains patent is then called the canal of Nuck. Wrisberg, in 19 out of 200 female bodies found an opening leading through the ring into the labium lined by peritoneum. It may be the cause of a congenital inguinal hernia in the female. An account of the dissection of such a case by ourselves will be found in Vol. Lxx., No. 7, of this Journal.

In femoral, or crural hernia, we have always similar anatomical changes to deal with, without the variety of conditions which we have described in the inguinal forms. This is because the crural ring and canal are not pervious for the passage of any viscus like the testis through them. We have, it is true, a complex arrangement of fasciæ, which it is not necessary to dwell on here. But the pouch of peritoneum, forming the hernial sac, is always the same offset from the great peritoneal cavity; and the only difference is as to whether it be arrested at the crural ring or extend down through the saphenous opening.

In umbilical hernia, again, we have a simple and constant arrangement of parts. In infancy, the pouch of peritoneum protrudes through the unclosed fœtal opening for the umbilical cord. Its coverings are only the skin and superficial fascia. It thus becomes very thin; the peritoneum in old cases is nearly absorbed, and it seems as if the hernia might burst through. Such herniæ are very dangerous to meddle with by operative procedure. In the umbilical hernia of adults, occurring mostly in obese females, we quite frequently have the rupture protruding through a small opening in the sheath of the rectus, near the umbilicus; being really a ventral hernia, though appearing to be an umbilical one.

An imperfect nomenclature has given rise to most of the difficulty of understanding and describing hernia. Thus the two pillars of aponeurosis of the external oblique muscle, which environ the outer ring, called external and internal, should be called lower and upper. The outer abdominal ring, though outermost with reference to the plane of the abdominal muscles, is innermost with reference to the median line of the body; and the inner abdominal ring, in like manner, is farthest out from the median line.

So, too, oblique inguinal hernia is called external, because it passes outside the epigastric artery, although it emerges from the abdomen through the inner ring; and direct inguinal hernia is called internal, because it lies inside the epigastric artery, although it passes directly out of the external abdominal ring.

If possible, a worse confusion occurs in naming the fasciæ concerned in femoral hernia.

Thus we have the iliac portion of the fascia lata forming Hey's ligament, or the outer, falciform border of the saphenous opening; and the iliac fascia proper, lining the iliacus internus muscle within the pelvis, and forming the posterior half of the sheath of the femoral vessels. Also, the transversalis fascia forming, above Poupart's ligament, the posterior wall of the inguinal canal, and below the ligament, by another expansion of it, forming the anterior sheath of the femoral vessels, or fascia propria of femoral hernia.

In mapping out the anatomy of the inguinal region, the great land-mark is the spine of the pubes. It can always be felt, even in the most unfavorable subject. Into the pubic spine is inserted the lower or outer pillar of the outer ring; and passing across to the symphysis, just above the spine, is the upper or inner pillar of the same opening. Over and a little outside the spine of the pubes the external abdominal ring is inevitably to be found. It may be best felt in the male by placing the finger at the bottom of the scrotum, and invaginating it up into the ring. Just above, and at the middle of Poupart's ligament, is the internal abdominal ring. Below Poupart's ligament, and about midway between the outer and inner abdominal rings, is the crural or femoral ring.

These relations are constant, and by starting from the pubic spine we can make them all out.

Thus, we can distinguish a femoral from an inguinal hernia, even though the former be rolled up into the site of the latter, by either drawing down the tumor and seeing if the neck be below or above Poupart's ligament, or by finding the pubic spine, and exploring the external abdominal ring.

The statistics of the London Truss Society for twenty-eight years, embracing a total of 83,584 cases of hernia, go to prove:—

First, That hernia is more frequent in males than females, there being 67,798 males to 15,786 females—or four to one. This must be taken with some allowance for the fact that women are more apt to conceal, and less apt to seek aid for hernia, than men. But the great preponderance of males is probably to be explained by their more laborious pursuits.

Second, That hernia is more common on the right side than the left, in both sexes. Thus of males, 24,316 right side to 14,006 left, or 2 to 1. Females, 3,256 right to 2,255 left, or 3 to 2. Cloquet assigns as the cause of this, that in most severe labor we use the right side in such a way that a line drawn perpendicular to the plane of the diaphragm falls over the right inguinal region, and the strain comes on the openings of the right side.

Third, That inguinal hernia is the more common form in males, and femoral in females. Thus of inguinal hernia, 38,322 males to 1,097 females; and of femoral hernia, 699 males to 5,511 females. The cause is to be found in the anatomical differences of the sexes. In the male the inguinal canal is dilated for the testicle and cord. In the female the greater width of the wings of the ilium, and consequently of the femoral arch, leaves a larger crural opening, and predisposes to that form of hernia.

Fourth, That umbilical and ventral hernia are more common in females than males. Of umbilical, 2,775 females to 664 males. Of ventral, 415 females to 209 males. This is probably due to causes incident to pregnancy, and the separation of the recti muscles. According to Mr. Syme, the straining in labor is also a common cause of femoral rupture.

The real cause of hernia, apart from accidental rupture by sudden over-exertion, we believe to be, in great degree, hereditary; in other words, that a tendency to loose rings, or to various degrees of imperfect closure of the funicular process of peritoneum, runs in families, or descends from father to son. Great length of the mesentery or omentum has been assigned as a cause, but this would seem to be negatived by the occurrence of hernia in children, in whom those structures are very short.

The mode of formation of the hernial sac is of interest and importance. This pouch of peritoneum is distinguished into a neck, where it emerges from the rings; a body, and a fundus or dilated extremity. In the congenital hernia the neck is nearly as broad as the fundus. In the ordinary adult hernia the neck is narrow. In some sacs there may be one or more constrictions outside the rings; and there may be two, or even more sacs, in the same region, as figured by Cooper. The sac of peritoneum elongates and stretches as the rupture increases by the *vis à tergo* within the abdomen; and it, before long, becomes organized and thickened, and contracts adhesions to the scrotum and inguinal canal. Thus it happens that in very many herniæ, perhaps the majority, the sac becomes irreducible back into the peritoneal cavity, although the bowel can be returned within the abdomen. We may have a hernia, without a sac, of the cœcum, or colon, or bladder, or any viscus which, not wholly enveloped by peritoneum, can slide down behind it.

Although the sac be adherent, if its contents can be pushed back into the abdomen, it is called a *reducible* hernia. But adhesions are very apt to take place between the contents of the sac, whether intestine or omentum, and the sac itself, as well as of the latter to the surrounding parts. If both these events occur, the hernia is called *irreducible.* If, now, a temporary stoppage of the peristaltic action of the bowel in the rupture takes place, through the accidental presence of flatus or a fœcal mass, the hernia is called *incarcerated.* If this state of things continues unrelieved we have, next, *inflammation.* Here the position of affairs has become critical, but *may* be relieved by fomentations, rest, opium, &c. But, finally, if either the above condition continues in an irreducible hernia, or arises *de novo* in a reducible rupture—which has got suddenly down and been nipped, as it were, unawares—we have next *strangulation,* mortification and death, unless relieved by an operation.

CASE OF RETAINED CATAMENIA.

To the Editors of the Boston Medical and Surgical Journal.

THE following may not be uninteresting to young readers. April 2d, I was called to visit Mrs. R., whom I found suffering from an attack of remittent fever. After prescribing for her, she called my attention to her daughter—a girl of 15 years. Upon inquiry, I learned that she was suffering from severe pain in the lumbar region, which she described as "bearing-down" pain. I was told that she had never menstruated, and this fact, together with her age, development of mammæ, "bearing-down" pains and general *embonpoint*, naturally led me to the conclusion that I had to deal with a case of suppressed catamenia. I therefore ordered a brisk cathartic and emmenagogue of aloës, ferri sulphas and ext. hyoscyami. Next day, finding the pains aggravated, with no good results, I requested an opportunity to examine the case *per vaginam*, which after some hesitation was accorded.

Upon examination, the first thing that met my touch was the meatus urinarius projecting prominently beyond the labia. Between the labia I found an oval tumor, yielding a fluctuating feel to the finger; beyond this my finger could not pass, but by tracing its outline I found the tumor to be simply an imperforate hymen, which I presumed was distended by menstrual fluid, and that the uterus was making an effort to discharge still more, which was prevented by the distension of the vagina and the unyielding hymen. I therefore determined to perforate the membrane at once, which I did by means of a crucial incision. This was followed by a discharge of about a pint of dark, offensive blood—the accumulation of about a year, as I became satisfied by further inquiry. The membrane was about two lines in thickness. It is needless to say the operation gave complete relief at once.

I mention this case as one not very common in our practice. I should have stated that the rectum and bladder were evacuated before the operation, to guard against any possible danger to them.

Yours respectfully, H. C. ROBBINS.

Dement, Ill., May 30th, 1866.

Health of Philadelphia.—Previously to every epidemic of cholera which has prevailed in this city, an epidemic condition of the atmosphere has always manifested itself in an increase of deaths from bowel affections. No such condition of things seems to exist at the present moment. The whole number of deaths from cholera infantum, diarrhœa and dysentery, for the week ending May 26, was only six, in a mortality from all diseases of 238.—*Medical News and Library.*

Reports of Medical Societies.

EXTRACTS FROM THE RECORDS OF THE BOSTON SOCIETY FOR MEDICAL IMPROVEMENT. BY CHARLES D. HOMANS, M.D., SECRETARY.

MARCH 12th.—*Great Engorgement of the Lungs, with Œdema—Death —Autopsy.*—Dr. ABBOT reported the case. Was called suddenly a few evenings before, at 10 o'clock, to see Miss ———, aged 36 years, a dress-maker by trade, who was said to be in an alarming condition from sudden indisposition. Saw her in fifteen minutes, having met on his way a messenger despatched to hasten his steps. On his arrival he found the patient sitting in bed supported by her friends, with a basin before her containing two or three ounces of frothy sputa faintly tinged with blood, throwing herself from side to side in the most urgent distress, and begging most piteously for help. Another basin contained vomited matters, consisting of food, with considerable bile and traces of blood. Her countenance was intensely livid, as much so as in the collapse of Asiatic cholera, her lips slate color, her hands icy cold, pulse almost imperceptible, and her skin bathed in perspiration. Her appeals for immediate relief were so importunate that it was difficult to obtain any very definite idea of the special nature of her attack. The friends stated that she had been regarded for some time by her physician as the subject of disease of the heart. Her complaint at the moment, however, was not of dyspnœa, but of a general feeling of indescribable distress, most aggravated at the epigastrium. An occasional cough produced a rattling in the throat, but there was very little expectoration. A hurried examination of the heart, the patient being almost constantly in motion, detected no abnormal sound. A rapid exploration of the back showed that the air penetrated to the base of both lungs, but that the respiration was very peculiar. It had a remarkably hoarse character, and yet suggested the idea of air passing over a moist membrane; none of the character of genuine bronchial respiration. No true rales were detected anywhere. The restlessness of the patient and the extreme urgency of the case did not admit of prolonged or very exact auscultation. As soon as it could be prepared a stimulant, hot whiskey and water, was brought, but the patient suddenly fell back dead at the moment it was presented to her lips. She died instantly, respiration and circulation seeming to stop together and at once. Immediately there poured from the mouth and each nostril a stream of white froth which resembled nothing so much as the overflow of an ale bottle. This continued, requiring constant removal so long as Dr. Abbot was in the house.

On subsequent inquiry it was learned that the patient had been for several years in rather delicate health, being subject to faint turns accompanied by vomiting. Frequently on entering the house she had been obliged to rest before going up stairs. She had been under treatment at the Boston Dispensary several times during the previous three months. Her physician arrived before Dr. Abbot left the house, and stated that he had found signs, as he thought, of tuberculosis at the summit of the lungs, and there had been some interruption to the catamenia; for this condition he had prescribed cod liver oil and a preparation of iron. He had not detected any disease of the heart. The history of the present attack, as learned from the sisters of the deceased, was as follows:

The patient occupied a room by herself at the west part of the city, being employed much of her time in sewing at a place some distance from her lodgings. On Thursday, the first instant, she went to her work, as usual, but feeling unwell left at noon and returned home. She did not, however, confine herself to the house, but busied herself about her affairs during the afternoon, and was a considerable time out of doors, the weather being disagreeable and chilly. She passed an uncomfortable night, and had cough for the first time on rising the next morning. She felt so poorly that she was unable to kindle a fire in her room, but sat alone until midday, enveloped in a shawl, although the day was cold and threatening a storm. In the evening she was found by her sister in a miserable condition, exhausted by a frequent cough, with vomiting at times. She was unwilling she should remain where she was during the night, and persuaded her to accompany her to her own lodgings at a distance of perhaps half a mile. This she did on foot, although the ground was covered by an inch or two of fresh-fallen show, and the snow was still falling. Her path led her up the steepest side of the highest hill in the city, and on her way she was obliged to rest on a door step for a while on account of a feeling of faintness which was accompanied by vomiting. With some effort she succeeded, however, in reaching her journey's end on foot. It is somewhat remarkable that she did not complain especially of dyspnœa when climbing the hill. She reached her sister's room at about nine, P.M., only an hour and a quarter before she died.

Autopsy sixty-two hours after death. As the weather had been cold since the patient's death (the temperature being most of the time near the freezing point), and as the outer air was admitted freely to the room, and a large mass of ice had been kept on the body, there was no sign of decomposition. Considerable deposit of fat under the skin, the body generally showing no indication of emaciation. On opening the chest, the right lung was found everywhere firmly attached to the chest by old adhesions, and the lobes of the lung were also firmly adherent to each other. There were two or three ounces of bloody serum in the right thoracic cavity. The lung throughout had a firm, fleshy feel to the touch, and did not crepitate anywhere on pressure, except a small portion of the upper part of the upper lobe. When cut into, it was of a deep red color throughout, and the cut surface everywhere poured out a copious frothy serum, slightly reddened. The left lung was in a similar condition to the right, although the adhesions to the thoracic walls were much less extensive; the lobes were closely adherent to each other. The pulmonary tissue was somewhat less red than that of the right lung, and pressure produced moderate crepitus throughout, although the lung had a good deal of the fleshy feel of the right. No tubercles were seen anywhere, although special search was made for them at the summits of both lungs, where they had been thought to exist by the patient's physician. A single cretaceous body, about the size of a raisin-seed, was found on the surface of the left upper lobe towards the base in front.

Heart.—The heart was contracted and empty, its only contents being a few fibrinous shreds hanging about the chordæ tendineæ of the tricuspid valve. There was nothing whatever abnormal in its structure.

Abdominal Viscera.—The liver was of a deep red color, seemingly crowded with blood, and the kidneys were in a similar condition, presenting no other abnormal appearance. The spleen was apparently healthy. The other abdominal and the pelvic viscera presented nothing unusual in their appearance, but were not specially examined.

Dr. Abbot said he was induced to report this case somewhat in detail because on a former occasion, when the subject of congestion of the lungs had been under discussion, some members of the Society had expressed themselves as exceedingly skeptical on the subject of this disorder, some even going to the extreme of almost questioning whether there were such a morbid condition. It certainly is a complaint of which very little mention is made by medical writers under this name, although it is an expression in very common use both in and out of the profession. Although he doubted very much the accuracy of the diagnosis which ascribes in the weekly mortality tables the decease in so many instances to congestion of the lungs, he could not but think that there is such a disease, although rare, and could not help regarding the case reported as an instance of it. The special symptoms which inclined him to this view were the absence of moist rales during life, the penetration of the air throughout the lungs, and the slight expectoration, with the bloody tinge which it presented. At the same time it must be admitted that during the few minutes that elapsed before the death of the patient, after his arrival, there was no special complaint of dyspnœa, although she was evidently dying of asphyxia; the distress was referred wholly to the epigastrium. Neither had there been any particular complaint during the fatiguing walk just before, except of weakness and nausea. The solidification of the lung was undoubtedly due to the *post-mortem* effusion of serum, which, as has been stated, showed itself by unmistakable signs immediately after death. Is it not probable that the peculiar modification of the respiration was due to the crowded condition of the bloodvessels of the lungs, which poured forth a copious exudation at the moment of dissolution, just as the cutaneous surface sometimes pours forth a profuse perspiration in syncope?

Dr. Ellis at a previous meeting had expressed his doubts concerning the character of the cases so frequently reported as *congestion of the lungs*, and he repeated the remarks made at that time, though he did not consider them entirely applicable to Dr. Abbot's case.

The conclusion that such congestion exists is based upon phenomena noticed before death and upon *post-mortem* changes.

The symptoms upon which stress is principally laid are, dyspnœa and râles diffused throughout the chest. These are met with under two principal conditions; first, as the closing manifestations of protracted disease, the tendency of which is to produce dropsy; second, in the midst of health, when they are developed with astonishing rapidity, and may soon terminate in death.

In the first class of cases, the heart may or may not have been affected, but as soon as râles are detected in the lungs, pulmonary congestion is announced and supposed to be the cause of death, which soon follows. Now these râles indicate only the presence of fluid in the air-passages, and, although disease and direct experiment show that obstruction of the circulation *may* give rise to effusion of serum, it is perfectly well known that the same may take place *without congestion*, and we have learned at autopsies that the latter may be so extreme as to terminate in pulmonary apoplexy, with little or no escape of serum; and, even in those cases of cardiac disease where the pulmonary vessels are for many months crowded with blood, it is only towards the close that œdema supervenes. Congestion may be the primary cause, but râles are not sufficient to prove it.

In the second class of cases, the symptoms are the same, but all other conditions are changed. We have the same widely-diffused râles and urgent dyspnœa. Consequently it is assumed that the pulmonary vessels have in some inexplicable manner become congested, and that the other manifestations are simply the consequences of these. We can only say that the question cannot be regarded as settled as long as we have reason to believe that congestion is not necessary for the production of œdema. It is as difficult to accept primary congestion as it is to accept primary œdema. The reserved or perverted power of the tissues is sufficient to explain a sudden formation or excess of that watery fluid, with a certain quantity of which they always provide themselves.

If we must assign some position to such cases, it does not seem improper to class them with *capillary bronchitis*, which they at least closely resemble, and of which the reported lesion is fully adequate to produce the observed phenomena.

In regard to the *post-mortem* changes, too much caution cannot be used in interpreting them. It is impossible to describe in words appearances which necessarily indicate morbid congestion. The blood-vessels in all parts of the body of a healthy person dying after a short illness contain a much larger amount of blood than those of patients who have yielded to protracted and wasting disease, and every hour that elapses after death increases the danger of deception, by favoring physical changes which it is often extremely difficult to appreciate.

It appears, in addition, to be quite evident that the marked œdema which is so often cited as a proof of congestion cannot be accepted as such without great reservation. We must also remember that this same œdema may, by obstructing the entrance of air, actually cause the congestion.

Without, therefore, denying the existence of congestion of the lungs as a disease, it may with propriety be maintained that its phenomena are very incompletely understood, and that the readiness with which it is diagnosticated and announced as a cause of death cannot be too much deprecated.

JAN. 22d. — *Permanent Dislocation of the Patella outwards.* — The patient, a boy aged 14–15, was presented to the Society by Dr. COOLIDGE, who gave the following history of the case:

Three years ago, while skating, he fell on the ice, striking his knee. After half an hour was able to continue skating. He perceived nothing unusual for the next two or three days; his knee then became swollen and painful, and he was obliged to go to bed, where he remained five months. His knee was poulticed and leeched. When he got up, his knee presented its present appearance. The patella is dislocated outwards, its external facet apparently resting on the external condyle, tilting the internal border forward. The groove between the condyles can be easily felt. The ligamentum patellæ stretches upwards and outwards, and keeps the point of the bone fixed. It is narrower than on the other side, as if it had been partially ruptured. The deformity is greater on flexion than on extension. The oniy muscle which seems to contract with any energy in walking is the vastus externus. It is difficult to say how much the connection between the vastus externus and rectus and the patella has suffered. There is to the touch an indistinct transverse groove above the patella, as if there had been a partial rupture there.

The patient complains of nothing but a slight limp in walking, which prevents his getting a situation he desires. He wants to have the patella put back. It is, however, firmly kept in its present position. The attempt at reducing it is not considered justifiable.

Permanent dislocation of the patella is so rare an accident that two plaster casts of the knee were taken and were deposited in the Medical College Museum.

It is reported that Dupuytren in his lifetime met with but three dislocations of the patella; Boyer with one; Sir Astley Cooper with one; Liston with none. Malgaigne has collected (1855) 25 outward dislocations, two of which he saw himself.

MARCH 12th.—*Urinary Calculi.*—Dr. WARE exhibited specimens of urinary calculi taken from the bladder after death. They were removed from a gentleman 65 years of age, who called upon Dr. Ware eighteen months since with retention of urine from an enlarged prostate. He was relieved, and taught to pass the catheter, which he was occasionally obliged to do for himself from that time forward. In November last, Dr. Ware was called to see him, and found him in great pain from retention, with inability to pass the catheter, the attempt to do which had been followed by blood. He was relieved at the time; but as his symptoms indicated calculus, he was carefully examined for stone, under the influence of ether, by Dr. Ware and Dr. Cabot; no evidence of stone was discovered. As the pain continued, accompanied by copious discharges of bloody mucus and pus, it was regarded as a case of inflammation of the bladder, probably malignant, although the microscope gave no evidence of malignancy. The pain was so severe as to require him to be much of the time under the influence of ether. He gradually sunk and died.

At the autopsy, there was found intense inflammation of the mucous membrane of the bladder, with quite extensive ulceration. There was great enlargement of the prostate gland. There were also found in the bladder four calculi of very irregular form, with sharp angles and very rough surface. Their character showed that they had been formed for the most part since the inflammatory process had been set up in the bladder, as they are the products of inflammation. If they existed at the time of the examination, they were probably pouched behind the prostate and escaped observation.

Dr. J. C. WHITE made the following report as to the weight and composition of the stones, viz.:—"The weight of the large stone is 160 grains, and of the four small ones, 45 grains. They are composed of urate of ammonia, urate of soda, triple phosphate of ammonia and magnesia, and uric acid."

MARCH 26th.—*Death resulting from the rupture of an old Adhesion* *between the Intestines and a Tumor of the Uterus.*—Dr. Read reported the case as follows :—

"Anne W., colored, married, æt. about 30, was supposed to be about eight months pregnant, and had not been conscious, from any symptoms of pain or otherwise, that she was in any way ill. A few days before her death, on one of the cold days in the second week of March, she went with her husband to the State House on business, and got one of her feet chilled almost to being frost-bitten, but from the effects of this she had recovered. On the evening of the day previous to her death she had a slight headache, which did not, however, prevent her keeping about the house, nor eating her dinner with as much relish as usual. After dinner (perhaps half an hour), her husband came to the house where she was, and was alone with her for half an hour. Almost immediately on his leaving her—he had hardly got into the street from the house—she complained of a "dreadful feeling at the stomach," called for a vessel, and began to vomit. This kept up, with sharp pains in the epigastrium, until about 5, P.M., when Dr. Damon saw her. All attempts to control the vomiting and pain were fruitless, from the impossibility of the stomach retaining anything. At Dr. Damon's request, I saw her with him, about 7, P.M. She was lying on the floor, on a bed, rolling in agony. A vessel at the side of the bed was about half full of very thick, ropy mucus, largely mixed with a coffee-colored material, in small bits about the size of a flax-seed. Her extremities were cold, and the pulse could not be felt at the wrist. At my suggestion, in consideration of the irritable condition of the stomach, one fourth of a grain of morphia in solution was injected into the right arm just above the elbow, for the purpose of alleviating the pain and disposition to vomit. This had the effect to abate the severity of the symptoms, and she made but one ineffectual attempt to vomit after its administration. In the course of half an hour, another injection of the same quantity was thrown in. Under the effect of both, the pulse came up strong and quick. She grew warm, and finally subsided into a comparatively quiet sleep. She was then left. The next time I saw her, at about 8, A.M., the day afterwards, she was moribund.

"The peculiarity of the symptoms and the suddenness of the seizure, together with the fact that she was alone with her husband, who had shown himself very indifferent to her comfort, and had for some time consorted with disreputable females, seemed to point to a cause beyond what would ordinarily be met with, and, with Dr. Damon's concurrence, the case was put in the charge of Coroner Underwood, by whose authority an autopsy was made, which revealed the cause of death. The examination was made by Dr. C. W. Swan, from whose minutes of the case I have copied the following :—

"Peritoneal cavity contained at least two quarts of a watery, gruel-like fluid, containing soft, dull, whitish, curdy or pulpy masses and flakes, and having a strong fæcal odor. There were no masses of lymph or general adhesions of intestines and other organs to each other; but the omentum and whole peritoneum was of a dull uniform slaty or ashen gray color, without vascularity. Uterus small; attached to its fundus posteriorly, was a firm, rounded tumor, five inches in diameter. It contained a considerable, irregular cavity, in which was a separable, broken up, but coherent series of masses, of a blackish chocolate color, resembling old putrid hard coagula of blood. At the upper and posterior side of the cavity, the walls were so thin as to be in two places perforated by two considerable openings, and to this point or region several folds or knuckles of the ileum were attached by blackish and not very firm false membranes. The omentum was also attached in a similar manner to the tumor. On separating the attachments with a knife, intestinal gas escaped, although the intestines had not been divided by this operation. The adhesions of the ileum were as follows:—two and three feet respectively, above the valve, discolorations but no perforations; nine feet above the valve, blackish discolorations and two perforations, rounded with smooth edges, one fourth and one eighth of an inch in diameter respectively, and one fourth of an inch apart, apparently not recent. About a foot from these perforations was a pair of discolored circular cicatrices, with some puckering of the surrounding mucous membrane. They were about one fifth of an inch in diameter.

"It is inferred, from these appearances, that the intestines had communicated for some time with the cavity of the tumor before the rupture of the adhesions in the vicinity occurred, which allowed the escape of the intestinal contents into the abdominal cavity which is regarded as the more immediate cause of death."

THE BOSTON MEDICAL AND SURGICAL JOURNAL.

BOSTON: THURSDAY, JUNE 21, 1866.

POISON ON DRAUGHT.

The occurrence of two cases of poisoning by the drinking of a strong solution of cyanide of potassium by mistake for iced water in this city within a few weeks, reveals a carelessness on the part of those who use this and similarly deadly substances which demands public attention. The first instance was recorded in a recent number of this Journal. A porter in a machine-shop, feeling thirsty dipped a tin cup into a jar of liquid, which he supposed to be water, and swallowed about three drachms before he discovered his mistake. In two minutes he became senseless, and was taken to the hospital, and, strange to say, after an emetic, the use of the stomach-pump and of ammonia, he recovered, for the amount of the poison swallowed was estimated at twenty-three grains, and thirty-five minutes elapsed before any of the remedies took effect.

The other case occurred a few days ago under similar circumstances. A thirsty man, a stranger amongst us, went into a jeweller's shop, and asked for a drink of water. He was directed to the rear where the sink was situated. Seeing a large covered stone jar standing near it, such as is often used for holding ice-water, he lifted the cover and drank, without stopping to look at it, about about half an ounce of the liquid. He became insensible in five minutes. It was found impossible to administer an emetic of sulphate of zinc in the apothecary's shop, whither he was at once taken, or later to use the stomach-pump at the hospital. He died in thirty minutes after drinking what he supposed to be a harmless draught of water. The liquid was a solution of cyanide of potassium in water, of the same strength as that swallowed in the first case, a pound to the gallon. The quantity taken was therefore about half a drachm of one of the most deadly poisons known, of which two or three grains are sufficient to kill a large animal, and five grains have destroyed human life in several instances. The prolongation of life in this, and the wonderful escape from death in the former case, were undoubtedly in great part owing to the fact that the stomach was filled with food, and that on this account the poison was not so rapidly converted into hydrocyanic acid and absorbed.

No coroner's inquest was held, we believe, but the case certainly was worthy of official inquiry, and although there was no doubt of the cause of death in this instance, and the circumstances were well understood, the opportunity should not have been lost of a public exposure and reprimand of such culpable carelessness. This preparation is largely used in the arts, and we doubt not that an investigation would show that this and other deadly poisons are to be found in scores of places in this city under circumstances which haste or ignorance, or a mere accident, might convert into a similar tragedy. The excuse that one should not be foolish enough to drink liquids from glasses and vessels without knowing what they contain, in no way justifies or palliates such occurrences. They can be prevented by the use of significant labels and by lock and key, and those who do not observe such proper precautions, should be held responsible for the results of their criminal indifference to human life. We are far too lax in our police regulations respecting the use and sale of poisons, and if the same energy which is exercised in the enforcement of the liquor and Sunday laws were turned in this direction, much good would result.

Messrs. Editors,—I send you a piece of a root supposed to be wild parsnip, and the account of a case of fatal poisoning by it.

A little girl, aged ten years, dug up at the side of a drain on the bank of a river, what was supposed to be wild parsnip, and ate part of it. This was about 11, A.M. At half past 12, P.M. she ate some milk. Soon afterwards she vomited, threw up the milk and small masticated portions of the root. She was then attacked with violent convulsions. Dr. Pierce was immediately sent for. He gave her an emetic, that soon operated. At 2, P.M., when I was called in consultation with Dr. Pierce, she was having almost constantly general convulsions. She had bit her tongue badly, and blood and mucus were running from her mouth. The convulsions resembled those of strychnine, with the exception of a want of consciousness and regular intervals between the paroxysms. The convulsions were so powerful that it was difficult to keep her on the bed. Her pupils were dilated to the greatest extent; in fact there did not seem to be any iris. Her extremities were cold, her pulse very rapid, varying from 130 to 160.

Two drops of croton oil were placed on her tongue, which soon operated. We gave her injections of assafœtida and brandy, and put her into the warm bath, where she appeared a little easier. Her convulsions continued till 5, P.M., when they entirely ceased, and she could swallow. Brandy was given her every fifteen minutes, and she once called for water. At 8, P.M. she was attacked as violently as before with convulsions. At this time her pupils were very much contracted. The muscles of deglutition, respiration and the diaphragm began to be much affected, and the respirations were very quick. She died asphyxiated, at 7 the next morning.

Winchester, N. H. SAMUEL P. FRENCH.

Death of Dr. Stedman.—Dr. Stedman, whose sudden death we announced last week, was born in Lancaster, of this State, on the 17th of June, 1805, and was consequently nearly sixty-one years of age. After completing a good elementary education at the best schools in the State, he studied medicine in Boston under the pupilage of Drs. James Jackson and Walter Channing, and received his medical degree from the Medical School of Harvard College, in 1828, having attended the usual number of courses of lectures by the professors of that university. Soon after taking his degree, he was appointed Surgeon and Superintendent of the United States Marine Hospital at Chelsea, and subsequently was Physician and Superintendent of the City Lunatic Hospital at South Boston, for several years, and at his decease was one of the Visiting Surgeons of the New City Hospital.

Notwithstanding his duties as a physician, he found time to devote himself to other occupations, and in 1855 served the city as a Senator in the Legislature of Massachusetts, and in 1856 and 1857 as a Councillor for the County of Suffolk; since which time he has assiduously devoted himself to the practice of his profession. In all matters relating to mental derangement he has for many years been considered an expert, and consequently has been frequently consulted in legal cases where doubts of sanity existed.

In the decease of this gentleman, the profession will feel a deep loss, and many of our poor citizens will miss a good friend.—*Sunday Times.*

The Portability of Cholera.—Although cholera is not contagious, it is portable, or at least its cause is. On this point will turn the wisdom or propriety of quarantine; and if I enter somewhat into detail in stating the facts which bear upon it, you will suppose that I am influenced by a desire that you should understand the question fully, and not prejudge it on the statements of those who have lost faith in this preventive measuse, while at the same time you acquire additional information regarding the habits of the disease. From our very first knowledge of cholera we have been familiar with the fact that it has marched from its home in the East along great travelled roads; that it has kept time with the movements of travel, or at least has not out-marched it; that it has followed the lines of commerce; that it sometimes attaches itself to armies and follows the course of their march over a large district of country, attacking certain towns and villages, and not attacking others in their course—thus discriminating because the conditions necessary for the regeneration of the poison exist in one and not in another. It has marched with caravans of pilgrims. Pilgrims from Mecca brought the disease into Egypt; and from Egypt it spread into various parts of Europe last year. It has marched with pilgrims from the East into Arabia. Indeed it is very generally asserted throughout Europe that only in isolated and exceptional instances is it found out of the line of travel and commerce; while Pettenkofer holds that no instance of supposed spontaneous origin will bear the test of close examination; that it always and everywhere in Europe originates in the action of choleraic evacuations upon the soil, these being discharged by a person arriving from an infected place, or by such a person travelling and leaving the noxious secretions on his way.

But the mode in which the disease crosses broad waters is more instructive. How, for example, did it first reach England? That country is separated from the continent by waters quite too broad to permit the wind to carry the poisonous principle from shore to shore; and as a matter of fact, the disease has first appeared there in regions where the sea is of the greatest width. The very first point invaded on the shores of England was Sunderland, near the parallel of 55°. To this place it was brought by trading vessels. The points where it has made its attack in every epidemic in England, except one, have been upon the eastern coast, and at one or other of the principal commercial towns, Hull, Sunderland, Newcastle; and in each instance the first cases occurred after the arrival of infected vessels. The same is true of its appearance at Edinburgh in Scotland, and at Dublin and Belfast in Ireland. It generally appeared in London only after it had made a landing in those more northern cities. In one instance, in the autumn of 1853, it occurred first in Liverpool, and a few days after at Newcastle, on the opposite coast. It occurred in Liverpool among the German emigrants who had just been landed there from Hamburg, where the disease was at the time prevailing. It was clearly carried there; it was in the ship during its passage from Hamburg to Liverpool. It soon became mildly epidemic in Liverpool, waiting, however, for the next warm season to become severely epidemic. Then it has crossed the Atlantic, and how? At one time it was fashionable to assume that the cholera marched by a certain steady progress; that it was caused by a great morbific wave rolling slowly and steadily eastward, and that it would envelop place after place at pretty regular intervals; but this opinion does not bear very close inspection. In its movements in India, at first its progress was about twenty-one miles a week; in its movements from the delta of the Ganges to Canton in China, going eastward, it travelled little more than ten miles in the week; when it reached Europe its progress was estimated at a greater speed, eighty or a hundred miles in the week; but a hundred was the highest figure assumed to represent its progress. Now dating from the time when cholera first appeared at Sunderland, in 1831, to the time when it first reached Quebec, and then New York, the rate of progress would hardly be greater than that indicated by the highest of these figures; but in subsequent epidemics it has crossed the ocean at the rate of three hundred and fifty miles and four hundred and fifty miles a week. Then, too, it appeared in England before it assailed the region intervening between Hamburg and the British Islands; and the question arises, if it depends solely upon such atmospheric wave, why were these intermediate places exempted? Again, when it came to this country, it first appeared at Quebec and Montreal. If that wave had rolled across the Atlantic, and so reached these cities, it must have passed directly over Nova Scotia, New Brunswick, and the northern part of Maine; and yet no disease was found there until long after it had made its way to New York, and thence spread in various directions. But we find that the brig *Carricks*, and another vessel bringing emigrants to Canada, reached Gros Island, the quarantine grounds of Quebec, and thirty-nine miles below it, on the 3d June, 1832, having cholera on board, and that the emigrants of these vessels were taken by a steamer from the quarantine grounds; that some of them were landed in Quebec and some in Montreal; and in two days from the time this steamer reached each of these cities, that is, on the 8th and 10th of June, the disease broke out in those towns; and that it gradually spread to become a severe epidemic.—*Extracted from Prof. Clark's Lectures on Cholera, in New York Medical Record.*

The Annual Meeting of the New Hampshire Medical Society was held in Hanover on the 5th and 6th of June, 1866. The officers for the ensuing year are:—*President*, R. P. J. Tenney, M.D., Pittsfield; *Vice-President*, A. H. Robinson, M.D., Concord; *Secretary*, Nathan Call, M.D., Suncook; *Treasurer*, Thomas Wheat, M.D., Manchester. *Delegates to other State Medical Societies*:—To Massachusetts, Dixi Crosby, M.D., Hanover, P. A. Stackpole, M.D., Dover; to Rhode Island, N. W. Oliver, M.D., Portsmouth, A. H. Robinson, M.D., Concord; to Connecticut, L. M. Knight, M.D., Franklin, S. L. F. Simpson, M.D., Concord; to New York, J. P. Bancroft, M.D., Concord, G. A. Crosby, M.D., Manchester; to Vermont, Dixi Crosby, M.D., Hanover, John Clough, M.D., Lebanon; to Maine, L. G. Hill, M.D., Dover, T. J. W. Pray, M.D., Dover; to New Jersey, E. K. Webster, M.D., Boscawen, L. C. Bean, M.D., Lebanon.

N. Call, *Secretary of the N. H. Medical Society.*

Suncook, N. H., June 16th, 1866.

Medical Intelligence.—A recent number of Virchow's Archiv contains an account of the discovery, during amputation of a cancerous breast, of trichinæ in the underlying muscular tissue. On microscopic examination the entozoa were found free and encapsuled, and alive. From the history of the case it appeared beyond a doubt that the invasion took place in 1842, or 24 years ago, at which time two members of the patient's family died with symptoms like those under which she also then suffered. This is the longest time on record that these entozoa have been known to exist within their human host. The investigations conducted by the commission of the Chicago Academy of Sciences, which are entirely reliable, revealed the fact that of 1300 hogs examined, 25 contained trichinæ, or more than two per cent. This proves that we cook our pork more thoroughly than the Germans.

A new element has been introduced into clinical instruction in Vienna. At the request of Prof. Oppolzer, Dr. Stricker, assistant of Prof. Bruecke, has been appointed Adjunct to his clinic, and will have charge of all matters relating to physiological pathology, pathological chemistry and microscopy.

M. Charriere, the celebrated Paris surgical instrument maker, has disposed of his establishment to MM. Robert and Collin, formerly his pupils.

The University of Edinburgh has conferred the honorary degree of LL.D. upon Prof. Huxley, Hunterian Professor in the College of Surgeons, and Dr. Rae, the well known Arctic explorer.

The following is a list of the present professors of the Paris School of Medicine:—Medical Natural History, Baillon; Physiology, Longet; Accouchements, Pagot; Therapeutics and Materia Medica, Trousseau; Legal Medicine, Tardieu; Pharmacology, Regnauld; Surgical Pathology, Gosselin; Pathological Anatomy, Laboulbéne; Medical Pathology, Behier; Hygiene, Bouchardat; Clinical Medicine, Bouillaud, Guillot, Grisolle and Piorry; Clinical Surgery, Dolbeau, Langier, Velpeau and Nélaton; Clinical Midwifery, Depaul; Diseases of Skin, Hardy; Diseases of Children, Roger; Diseases of Eye, Foucher.

A prize of 50,000 francs is offered by the French government for the discovery of the most important application of the voltaic pile to industrial and scientific purposes. Competition is offered to all nations, and the claims will be examined in five years.

The destruction by fire of the University Medical College of New York, with the valuable Museum of Dr. Mott and the collections of the Lyceum of Natural History, and the burning of a large part of the newly-formed and extensive collections of the Chicago Academy of Sciences, should turn the attention of the custodians of other museums to the condition of the buildings under their charge. They should be made fire-proof as far as possible, or fires should only be allowed in those portions of the building which are thus protected.

Dr. Freeman J. Bumstead has been appointed Professor of Materia Medica and Clinical Medicine, to fill the vacancy caused by the death of Prof. Joseph M. Smith, in the College of Physicians and Surgeons, New York.

VITAL STATISTICS OF BOSTON.

For the Week ending Saturday, June 16th, 1866.

DEATHS.

	Males.	*Females.*	*Total*
Deaths during the week - - - - - -	42	46	88
Ave. mortality of corresponding weeks for ten years, 1855—1865	35.8	35.7	71.5
Average corrected to increased population - - - -	00	00	77.98
Death of persons above 90 - - - - - - -	0	0	0

Errata.—Two important typographical errors were made in Dr. Bowditch's article on Aneurism, in our last number. *First.* In the account of the previous health of the patient, instead of pains in the "throat," read *thorax.* *Second.* Instead of making Hippocrates suggest "dry lint" in the treatment of varices, it should be *dry diet.*

Deaths in Boston for the week ending Saturday noon, June 16th, 88. Males, 42—Females, 46. Aneurism, 1—apoplexy, 1—congestion of the brain, 1—disease of the brain, 1—bronchitis, 2—burns, 1—cancer, 1—consumption, 26—convulsions, 1—croup, 2—debility, 2—diarrhœa, 1—diphtheria, 1—dropsy, 1—dropsy of the brain, 5—drowned, 1—dysentery, 1—scarlet fever, 2—typhoid fever, 1—recto-vesico-vaginal fistula, 1—gangrene, 1—disease of the heart, 4—malformation of the heart, 1—hip disease, 1—infantile disease, 4—intemperance, 1—disease of the liver, 1—inflammation of the lungs, 2—marasmus, 4—old age, 1—paralysis, 3—premature birth, 1—puerperal disease, 2—scrofula, 1—smallpox, 1—ulcer, 1—unknown, 5—whooping cough, 1.

Under 5 years of age, 31—between 5 and 20 years, 5—between 20 and 40 years, 22—between 40 and 60 years, 13—above 60 years, 17. Born in the United States, 57—Ireland, 25—other places, 6.